

In accordance with the requirements of the Chapter 190, RSMo, and the applicable regulations, this application is hereby submitted for designation as a stroke center. Please complete all information.		
CURRENT STROKE CERTIFICATION ORGANIZATION		
☐ The Joint Commission ☐ DNV-GL Healthcare ☐ Healthcare Facilities Accreditation Program		
CURRENT STROKE CERTIFICATION LEVEL		
☐ Comprehensive Stroke Center ☐ Primary Stroke Center ☐	Acute Stroke-Ready Center	
HOSPITAL INFORMATION NAME OF HOSPITAL (NAME TO APPEAR ON DESIGNATION CERTIFICATE) TELEPHONE NUMBER		
NAME OF HOSPITAL (NAME TO APPEAR ON DESIGNATION CERTIFICATE)		TELEPHONE NUMBER
ADDRESS (STREET AND NUMBER)	CITY	ZIP CODE
PROFESSIONAL INFORMATION		
CHIEF EXECUTIVE OFFICER	CHAIRMAN/PRESIDENT OF BOAR	RD OF TRUSTEES
STROKE MEDICAL DIRECTOR (NAME, EMAIL, AND CONTACT PHONE NUMBER)	STROKE PROGRAM MANAGER (NAME, EMAIL, AND CONTACT PHONE NUMBER)
SECTION B		
The following should be submitted to the department as indicate	d:	
Proof of stroke certification with the Joint Commission DNV-G	Healthcare or Healthcare	Facilities Accreditation Program with the
Proof of stroke certification with the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program with the expiration date of the certification.		
Copy of the final stroke survey results from the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program.		
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Copy of the final stroke survey results from the Joint Commission If applying for Acute Stroke-Ready/Level III Stroke Center design		
If applying for Acute Stroke-Ready/Level III Stroke Center design Formal agreement with Level I or Level II stroke center for physicia	ation, the following should	be submitted to the Department:
If applying for Acute Stroke-Ready/Level III Stroke Center design Formal agreement with Level I or Level II stroke center for physicia therapy and the care of the patients post-thrombolytic therapy.	ation, the following should	be submitted to the Department:
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